IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

January 21, 2009

Daphne King
P.O. Box 764
Meridian, Idaho 83680

RE: Waterford Home Health Agency, provider #137092

Dear Ms. King:

This is to advise you of the findings of the Medicare/Licensure survey at Waterford Home Health Agency which was concluded on January 8, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 3, 2009**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

for

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw

Enclosures

February 4, 2009

State of Idaho
Department of Health and Welfare
Bureau of Facility Standards
P.O. Box 83720
Boise, ID 83720-0036

Dear Ms. Creswell,

Please find enclosed the plan of correction for the Statement of Deficiencies/Plan of Correction Form CMS-2567 and the similar form listing licensure deficiencies that was received by us on 1/26/09. **Waterford Home Health Agency's** plan of correction has been listed in the column left of the deficiencies.

Please also note that a one day extension for filing the plan of correction was received from Nicole on 2/3/09 at 1320.

If you have any questions or need additional information, please give me a call at (208) 884-3308.

Sincerely,

Daphne C. King

Daphne C. King
Administrator

3-1-09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	01/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD HOME HEALTH AGENCY	3975 EAST FRANKLIN ROAD MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the survey were: Teresa Hamblin RN, MS, HFS, Team Leader Gary Guiles, RN, HFS Acronyms used in this report include: BG - Blood Glucose HHA - Home Health Agency LPN - Licensed Practical Nurse MD - Medical Doctor MSW - Medical Social Worker POC - Plan of Care Pt - Patient PT - Physical Therapy RN - Registered Nurse CMS - Centers for Medicare and Medicaid Services POC - Plan of Care SN - Skilled Nursing SOC - Start of Care	G 000	RECEIVED FEB 04 2009 FACILITY STANDARDS	3-1-09 per phone Conversation with Daphne Keng, Administrator or 2-12-09 4:00pm
G 114	484.10(e)(1(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay. This STANDARD is not met as evidenced by:	G 114	**G114 – Patient Liability for Payment** Administrator and Director of Professional Services (DPS) to review and revise policies 2.7 Payer Source Verification and 15.6 Client Consent for services. Visit staff to be in-serviced by 3/1/09 on these policies and accurate completion of the client consent. On 1/9/09, the Patient Care Coordinator was verbally instructed on the correct method these forms were to be completed. The Patient Care Coordinator will now monitor on-going with each new start of care. Any discrepancies to be noted and reported to the Administrator and DPS for immediate correction and individual staff re-education. Accuracy of completion to also be monitored through periodic and quarterly chart reviews.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daphne C Keng — TITLE: Administrator — (X6) DATE: 2/4/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 114	Continued From page 1 Based on review of clinical records and interview with HHA staff, it was determined the HHA failed to ensure 6 of 14 patients (#7, #11, #4, #8, #13, and #6), whose records were reviewed, were informed in writing the extent to which payment could have been required from the patient. This had the potential to interfere with the patient's right to make informed decisions about whether to proceed with home care services. Finding include: Patient #7 was admitted to HHA services on 11/28/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient. Patient #11 was admitted to HHA services on 12/17/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient. Patient #4 was admitted to HHA services on 12/22/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient. Patient #8 was admitted to HHA services on 11/2/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient. Patient #13 was admitted to HHA services on 11/10/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment	G 114		

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G 114	Continued From page 2 might have been required from the patient. Patient #6 was admitted to HHA services on 09/04/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient. During an interview on 1/6/09 at 3:30 PM, the Administrator confirmed the identified patients were not informed in writing of potential financial liability or lack thereof. She acknowledged that patients should have been informed in writing.	G 114		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the HHA failed to ensure the clinical record established effective interchange, reporting, and/or coordination of patient care in 3 of 14 patients (#2, #15, and #6) who received multiple services whose records were reviewed. This had the potential to impact quality of patient care. Findings include: 1. Patient #2, whose SOC date was 07/31/08, was admitted for care primarily related to a urinary tract infection. A form titled "Therapy Referral Form" documented that the patient needed help with a new gluten free diet. A physician's order, dated 7/30/08, documented a	G 144	**G144 – Coordination of Patient Services** Administrator and DPS to review and revise policies 13.9 Progress Notes, 13.2 Client Clinical Records, 14.3 Client Care Conferences and 6.5 Documentation Guidelines. Staff will be in-serviced regarding policies and the accurate/proper methods for documenting in the medical record. Visit staff to be in-serviced on these policies and proper documentation by 3/1/09. On-going monitoring will continue through quarterly chart reviews to be conducted by the Touchmark RN nurse consultant. And, daily review of visit notes and physician orders by the DPS Patient Care Coordinator.	

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G 144	Continued From page 3 request for a Dietary Consultation. There was an undated, unsigned note written diagonally across the form in pink highlighter pen stating the patient had refused. No reason was given for the refusal or how this information had been communicated from the patient. There was also no documentation found in the clinical record that dialog had occurred between the Dietician or Nurse Case Manager related to the patient's refusal to accept the Dietary referral or that the physician had been contacted. During an interview on 1/5/09 at 1:53 PM, the Administrator confirmed the missing details in the communication (date, time, signature, explanation). The documentation was ineffective in communicating clear information. 2. Patient #15 was an 83 year old male whose SOC was 11/17/08. His diagnoses were glucocorticoid deficiency and diabetes. He also had a colostomy. He lived in an assisted living facility that was owned by the agency's parent company. A "Scheduled Visit Change Report" form, dated 11/25/08 and written by the physical therapist, stated "Pt having bowel accident from colostomy & had blood in feces." "Resident Notes", dated 11/25/08, were obtained from the assisted living facility on 1/7/09. The note, written by the assisted living facility's LPN, stated the resident's colostomy bag was "1/2 full of burgundy and red stool...Resident states 'This happens every 5-6 weeks and lasts 4-5 days. Order faxed for signature." Assisted living facility staff obtained an order to hold the patient's aspirin for 7 days when he had blood in his stool. Agency staff met on 11/26/08. The "Case Conference Summary" from this meeting did not mention the bloody stool. Subsequent nursing notes, on December 8, 15, and 24, 2008, did not mention	G 144		

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G 144	Continued From page 4 the bloody stool or resulting orders. Staff A, the patient's RN Case Manager, was interviewed on 1/7/09 at 4:00 PM. She reviewed the record and confirmed the record did not include documentation of coordination of care with the therapist or the assisted living facility. 3. Patient #6 was a 73 year old female whose SOC was 9/4/08. Her diagnosis was a progressive neurological disorder. An order for social services, dated 11/6/08, stated the MSW was to see the patient 2-3 times a month for 2 months. MSW notes documented 6 social service visits to the patient between 11/6/08 and 12/16/08. The patient was recertified on 1/3/09. A new POC was not present in the record and it was not clear if the MSW planned to continue to see the patient or not as of 1/6/09. Staff D, the RN Case Manager for Patient #6, was interviewed on 1/6/09 at 10:30 AM. She confirmed minutes of case conferences and nursing notes did not document coordination with the MSW. She said she had talked with the MSW the week before Christmas and said the MSW was planning to continue to provide services. Staff D stated she had not documented this and said due to the holidays, some of her charting had not been completed yet.	G 144		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on review of clinical records and HHA policies, and interview with HHA staff, it was	G 158	**G158 – Acceptance of Patients, POC, Med Super** Administrator and DPS to review and revise policies 6.5 Hold Resume Requirements and 6.3 Client Plan of Care. Visit staff to be in-serviced on these policies, resumption of care procedure, cancelled missed visit report and scheduling procedure that	

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G 158	Continued From page 5 determined the HHA failed to ensure care followed a written plan of care approved by a doctor in 7 of 15 patients (#8, #2, #12, #13, #1, #10, and #14) whose records were reviewed. This resulted in unreported missed nursing visits, an unreported missed dietary consultation, a failure to assess and instruct a diabetic patient per POC, and patients receiving skilled care without current orders. Failure to ensure care followed a written plan of care established by a doctor had the potential to negatively impact patient outcomes. Findings include: 1. Patient #8, whose SOC date was 11/22/08, was admitted to the HHA for care related to a stroke. After the first week of care, SN visits were ordered 1-2 times per month for 2 months. There was no documentation found in the clinical record to indicate any nursing visits had been made during this time frame or that the physician had been notified as to the reason nursing visits had not been made. During an interview on 1/6/08 at 3:15 PM, the Administrator reviewed the record, confirmed the missed visits, and stated "I don't know why." 2. Patient #2, whose SOC date was 07/31/08, was admitted for care primarily related to a urinary tract infection. A form, dated 07/30/08 and titled "Therapy Referral Form," documented that the patient needed help with a new gluten free diet. A physician's order, dated 7/30/08, called for a consultation with a Dietician. An undated, unsigned note documented that the patient refused the consultation. There was no documentation found in the clinical record to indicate that the physician had been contacted regarding the patient's refusal to see the Dietician. During an interview on 1/5/09 at 1:53	G 158	coincides with the computer program utilized by the agency. In-service will be completed by 3/1/09. See also response to G144 as it relates to this citation. On-going monitoring will be conducted by the Patient Care Coordinator. DPS and/or Administrator to be notified when visit notes are missing and no schedule change request submitted by the visit staff. Monitoring will also be conducted through quarterly chart reviews by interdisciplinary team and RN nurse consultant. Use of the software program will be reviewed with the clerical staff for proper entry and tracking of all physician orders and the 485 (plan of care). This will allow for monitoring and tracking of the timing of 485 completion and submission to the MD. This review will be completed by 2/15/09.	

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G 158	Continued From page 6 PM, the Administrator reviewed the record and confirmed there was no documentation in the clinical record suggesting the physician had been notified of the patient's refusal to see the Dietician. Beginning 8/25/08 (week 4 of service), the POC, dated 07/31/08 for Patient #2, called for SN visits 1-2 times per week for 6 weeks. There was no documentation found in the clinical record that SN had made any visits to Patient #2 during week 8 or that the physician had been contacted regarding this missed visit. During an interview on 1/5/09 beginning at 1:53 PM, the Administrator reviewed the record and confirmed the missed SN visit and the lack of documentation regarding physician notification. 3. Patient #12, whose SOC date was 11/11/08, was admitted to the HHA for care primarily related to a failure to thrive. During week 4, the POC dated 07/31/08, called for 1-2 SN visits. No documentation was found to indicate any SN visit was made during week 4. During week 6, the POC called for daily SN visits. Documentation indicated that 6 of the 7 required SN visits were made during the week, including visits on 12/16/08, 12/17/08, 12/18/08, 12/19/08, 12/20/08, and 12/22/08. There was no documentation in the clinical record of a visit on 12/21/08. No documentation was found to indicate the physician was notified about the missed visits during week 4 or week 6. During an interview on 1/7/09 at 11:45 AM, the RN (Staff C) explained that SN missed the visit during week 4 because the patient had an MD appointment. She confirmed the physician was not notified. She stated that SN missed the visit for week 6 because she had asked the Assisted Living	G 158		

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G 158	Continued From page 7 Facility to check the patient's blood pressure. She did not offer an explanation as to why the HHA did not make the visit. She confirmed the physician was not notified. 4. Patient #13, whose SOC date was 11/10/08, was admitted to the HHA for care primarily related to her diabetes. The POC, dated 11/10/08, called for SN to assess diabetic control and instruct in diabetic care. There was no documentation found in the nursing progress notes from the SOC on 11/10/08 through the last filed nursing note on 12/27/08 that recorded any instruction in diabetic care or assessment of diabetic control, such as blood glucose results. During an interview on 1/7/09 at 2:27 PM, the Director of Professional Services (Staff B) reviewed the record and confirmed that documentation was missing in the clinical record showing diabetic assessment or instruction. During an interview on 1/7/09 at 2:40 PM, the Nurse Case Manager (Staff D) stated that she thought she had done some teaching but may not have documented it. She stated she could not specifically remember. 5. Patient #1 was a 92 year old male whose SOC was 8/12/08. His diagnosis was a deranged knee and he was admitted for PT. He was hospitalized on 8/18/08 for a seizure and released back to the care of hospice on 8/19/08. A "PHYSICIAN NOTIFICATION OF RESUMPTION OF CARE" order, dated 8/20/08, stated "MSW, RN for medication monitoring, RN: 1 wk 8". This order was dated as faxed to the physician on 8/27/08 and was signed on 9/10/08. The POC (CMS form 485) did not mention nursing services. A "Skilled Nursing Treatment Plan" was not documented. Nursing notes documented nursing visits on	G 158		

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G 158	Continued From page 8 August 20, 26, September 5, 10, and 26, 2008. The Director of Professional Services (Staff B) was interviewed on 1/5/08 at 2:30 PM. She reviewed the record and stated a POC had not been developed for nursing. 6. Patient #10 was a 75 year old male whose SOC was 10/30/08. His diagnosis was lung cancer with metastasis. A "Start of Care" assessment by the RN was dated 10/30/08. A "Skilled Nursing Treatment Plan" was documented as completed on that date. A "Resumption of Care" assessment by the RN was dated 11/7/08. It stated the patient had returned home after being hospitalized for one week. He was hospitalized from 10/31/08-11/6/08 for aspiration pneumonia. When patients are hospitalized, their POCs are no longer in effect because of the change in their condition. Following hospitalization, a "PHYSICIAN NOTIFICATION OF RESUMPTION OF CARE" form, dated 11/7/08, was completed. It stated "Added P.T." and listed orders for tube feedings and medication changes. It did not state the frequency of nursing or PT visits or describe what care the nurse or therapist were to provide for the patient. Nursing visits were documented November 10, 13, 17, 21, 25, and December 2, 5, 8, 15, and 24, 2008. PT visits were documented November 10, 14, 17, 21, 24, 25, 28, and December 1, 3, 5, 8, 10, and 11, 2008. These visits were not made under a POC established by a physician. The RN Case Manager for Patient #10 was interviewed on 1/7/08 at 10:00 AM. She confirmed a POC for this patient was not in place. 7. Patient #14 was a 39 year old female whose SOC was 12/17/08. Her diagnosis was hyperemesis gravidarum (vomiting during	G 158		

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G 158	Continued From page 9 pregnancy). A POC, CMS 485, was not present in her medical record. A "Skilled Nursing Treatment Plan", dated 12/17/08, was present in the record but it had not been signed by a physician. Staff C, Patient #14's RN Case Manager who was interviewed on January 7, 2009 at 11:28 AM, stated nursing visits had been made on 12/17, 12/18, and 12/19/08. She reviewed the record and confirmed a POC signed by the physician was not present. 8. The policy "CLIENT PLAN OF CARE", revised April 2007, stated the RN would conduct an initial assessment of the patient's "...problems, needs, and strengths." The policy said the list would "be utilized for the nursing care plan, therapy care plan, or personal services POC...The registered nurse, or therapist will develop the POC including a notation of the specific services to be provided, actions to be taken to meet the client's goals, and as appropriate, the type, frequency, and duration of such services or actions. The POC is documented on the (CMS form) 485." The Patient Care Coordinator was responsible for typing the POCs of the CMS 485 forms. She was interviewed on 1/7/08 at 1:20 PM and explained the process. She stated nurses and/or therapists completed the OASIS and other assessments and the treatment plans. She said these documents were submitted to her. Then they were given to the administrator for coding. Then they were given back to her and she scanned the OASIS assessment. She said the agency's software then generated a report of any inconsistencies in answers to the OASIS questions. Then, the Patient Care Coordinator stated the Director of Profesisonal Service (Staff B) reviewed the report with the RN Case Manager. Then, the Patient Care Coordinator	G 158		

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G 158	Continued From page 10 made changes to the to the OASIS assessment. Then, the Patient Care Coordinator typed the CMS 485 form. Then, the Director of Profesisonal Services (Staff B) reviewed the CMS 485 form. The Patient Care Coordinator then made any final changes to the form. Then Director of Profesisonal Service (Staff B) signed the form and it was sent to the physician for signature. A log of these times or dates when the form was completed, sent to the physician, and received back, was not kept. This made it impossible to determine when the POC was completed and completely implemented.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and agency policies, it was determined the HHA failed to develop plans of care in 3 of 15 patients (#4, #1, and #15) whose records were reviewed. This resulted in: 1) a patient with identified safety issues going without a coordinated plan of care for safety measures to protect against injury; 2) a diabetic patient going without a POC for diabetic assessment and management; and 3) a patient who had a history of not managing medication effectively going	G 159	**G159 – Plan of Care** Administrator and DPS to review the policy and procedure for the Fall Risk Assessment Form. The nursing plan of care worksheet will also be reviewed and revised to include safety measures for care planning if identified during the comprehensive assessment. The office procedure for submitting and faxing physician orders to be reviewed and revised to allow for a review of the plan of care prior to faxing to the physician by the DPS. Review and revision of the items noted in G159 will be completed by 3/1/09. Ongoing review and monitoring will occur through the quarterly chart review process identified earlier.	

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	137092	A. BUILDING _____ B. WING _____	01/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD HOME HEALTH AGENCY	3975 EAST FRANKLIN ROAD MERIDIAN, ID 83642

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G 159	Continued From page 11 without a plan of care to monitor medication compliance. The cumulative effect of a failure to develop plans of care was a reduction in overall quality of patient care. Findings include: 1. Patient #4, whose SOC was 12/22/08, was admitted to the HHA for care related to home dialysis. After shoulder surgery, he needed logistical help to perform the home dialysis. A "Client Fall Assessment," dated 12/23/08, concluded the patient was at high risk of falling related to multiple factors, including a history of falls, postural hypotension (a condition where the blood pressure drops upon standing), difficulty with transfers, agitation/increased anxiety, recent shoulder surgery, heart, neurological and orthopedic diseases. A form titled "Assessment of Need for Interdisciplinary Referral," dated 12/22/08 identified the patient as "frail with safety concerns, living alone - elderly." Nursing notes, dated 12/23/08 documented the patient reported having fallen that morning. Although, nursing notes, dated 12/22/08 through 12/24/08, indicated SN made attempts to address safety concerns with the patient, there was no documentation found in the clinical record that a plan of care was established in consulation with agency staff to address identified safety concerns. During an interview on 1/5/09 at 4:34 PM, the Nurse Case Manager (Staff D) described her initial impressions of Patient #4 as "impulsive, unsafe, and unsteady" and her ongoing impressions as "improved." She reported that the patient refused Physical Therapy services as well as aide or social work services. She confirmed that no written plan of care was established to address the fall risk and she explained that "fall risk" was not one of the selections available on	G 159		

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G 159	Continued From page 12 the Skilled Nursing Treatment Plan form. She stated "It is a gap." During an interview in the patient's home on 1/5/08 beginning at 8:10 AM, Patient #4 explained that he had fallen 5 times during an unspecified period of time, and two times since starting home care services. He was aware of his fall risk and did not want to leave his home until he died. The plan of care developed failed to address safety measures to protect against injury. 2. Patient #1 was a 92 year old male whose SOC was 8/12/08. His diagnosis was a deranged knee and he was admitted for PT. His orders included the medication Lamictal daily for seizures. He was hospitalized on 8/18/08 for a seizure and released back to the care of home health on 8/19/08. A "PHYSICIAN NOTIFICATION OF RESUMPTION OF CARE" order, dated 8/20/08, stated "MSW, RN for medication monitoring, RN: (1 time a week for 8 weeks)". An MSW assessment, dated 8/27/08, stated "4 days of missed Lamictal doses in the beginning of August, recent seizures". While the nurse had taken steps to improve medication compliance for Patient #1, a plan to do this was not present in his medical record. The Director of Professional Services (Staff B) was interviewed on 1/5/08 at 2:30 PM. She reviewed the record and confirmed the POC did not include monitoring the patient's medication compliance. 3. Patient #15 was an 83 year old male whose SOC was 11/17/08. His diagnoses were glucocorticoid deficiency and diabetes. His POC (CMS 485), dated 11/7/08, stated the nurse was	G 159		

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G 159	Continued From page 13 to visit the patient 1-2 times a week for 9 weeks. The plan did not include specific steps for the nurse to take regarding the patient's diabetes. Nursing notes documented the patient's BG at the initial visit on 11/17/08 was 300. The patient's BG levels on subsequent visits were: 11/21-299, 11/24-not documented, 11/26-visit not made, 12/8-298, and on 12/15-259 with a documented BG of 429 during the previous week. The nursing note for 12/24/08 noted the patient's BG was down to 215. The note stated the patient had visited his physician recently and his insulin dose had been increased. The POC stated the patient was on a regular diet with "low concentrated sugar". The POC did not include an attempt to evaluate or monitor the patient's food intake, nor did it include parameters regarding when the nurse should notify the physician regarding high BG levels. Staff A, the patient's RN Case Manger, was interviewed on 1/7/08 at 4:00 PM. She stated a specific plan to monitor the patient's diet and parameters for physician notification of high BG levels were not included in the patient's POC. She also stated the patient had seen his physician the week of 12/24/08, but said the visit was coincidental and was not the result of action taken by the agency.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records, it was determined the HHA failed to ensure professional staff alerted the physician to	G 164	**G164 – Periodic Review of Plan of Care** Administrator and Director of Professional Services to review and revise policy 8.1 Medical Policies and Physician's Orders. Visit staff to be in-serviced on this policy by 3/1/09. Ongoing review will occur through daily review of the visit notes by the Director of Professional Services.	

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G 164	Continued From page 14 changes in patient status in 2 of 15 patients (#12 and #15) whose records were reviewed. This interfered with the physician's ability to evaluate the patient's condition/situation and potentially change the plan of care. Findings include: 1. Patient #12, whose SOC date was 11/11/08, was admitted to the HHA with diagnoses that included anxiety and depression. The client medication list, dated 11/26/08, included two medications for depression (Citalopram 10 mg and Mirtazepine 7.5 mg) and one medication for anxiety (Alprazolam). A nursing note, dated 12/15/09, indicated the patient reported she had discovered she'd been taking twice the prescribed dosage of the Remeron (AKA Mirtazepine). There was no documentation to indicate for how long she had been taking the incorrect dosage. There was also no documentation that the physician had been contacted regarding this event. During an interview on 1/7/09, the RN (Staff C) stated she did not remember for how long the patient had been taking the incorrect dose. She confirmed the physician was not notified. 2. Patient #15 was an 83 year old male whose SOC was 11/17/08. His diagnoses were glucocorticoid deficiency and diabetes. His POC (CMS 485), dated 11/7/08, stated the nurse was to visit the patient 1-2 times a week for 9 weeks. The plan did not include specific steps for the nurse to take regarding the patient's diabetes. Nursing notes documented the patient's BG at the initial visit on 11/17/08 was 300. The patient's BG levels on subsequent visits were: 11/21-299, 11/24-not documented, 11/26-visit not made, 12/8-298, and on 12/15-259 with a documented BG of 429 during the previous week. The POC	G 164		

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G 164	Continued From page 15 stated the patient was on a regular diet with "low concentrated sugar". The POC did not include an attempt to monitor the patient's food intake, nor did it include parameters regarding when the nurse should notify the physician regarding high BG levels. Staff A, the patient's RN Case Manger, was interviewed on 1/7/08 at 4:00 PM. She stated she had not contacted the physician regarding the patients elevated BG levels. Also, she said she had not asked the physician what the parameters were for physician notification of high BG levels.	G 164		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on review of clinical records and interview with HHA staff, it was determined the agency failed to make on-site aide supervisory visits within the required 2 week period in 1 of 3 patients (#13) receiving aide services whose records were reviewed. A delay in supervisory visits resulted in a delay in assessment of the competence of the aide providing service, the satisfaction of the client, and the appropriateness of the plan of care. This had the potential to affect quality of patient care. Findings include: Patient #13 was admitted to HHA services on 11/10/08. Aide services were initiated on 11/12/08. The first supervisory visit was due on or before 11/27/08 but was not made until 12/2/08, 5 days late. The second supervisory visit	G 229	**G229 – Supervision** The agency currently utilizes the "Requirements Due Report" functionality within the software program. The report is printed and provided to each visit nurse to remind them of when supervisory visits are due. Effective 1/9/09, the Patient Care Coordinator has been instructed to also provide a copy of this report to the Director of Professional Services. The DPS will then monitor and follow up with any staff that is delinquent on making the required 14 day supervisory visits. These reports are printed weekly. Ongoing review for compliance will also occur through the quarterly chart review process and random review.	

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G 229	Continued From page 16 was due on or before 12/16/08 but was not made until 12/29/08, 13 days late. During an interview on 1/7/09 at 2:27 PM, the Director of Porfessional Serves (Staff B) confirmed the missed supervisory visits. She stated she did not know why the visits were late.	G 229		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and policies, it was determined the HHA failed to maintain clinical records in accordance with accepted professional standards for 4 of 15 patients (#4, #2, #6, and #14) whose records were reviewed. This resulted in poor coordination of care, a lack of clarity as to what services were actually provided, and whether identified patient needs were adequately addressed. Findings include: 1. Patient #4, whose SOC was 12/22/08 was admitted to HH services for care related to home dialysis. After shoulder surgery, he temporarily needed help to perform the home dialysis. A "Client Fall Assessment," dated 12/23/08 and completed by an RN, concluded the patient was	G 236	**G236 – Clinical Records** Please see response to G144 as it relates to this citation. ***G144 – Coordination of Patient Services*** *Administrator and DPS to review and revise policies 13.9 Progress Notes, 13.2 Client Clinical Records, 14.3 Client Care Conferences and 6.5 Documentation Guidelines. Staff will be in-serviced regarding policies and the accurate/proper methods for documenting in the medical record. Visit staff to be in-serviced on these policies and proper documentation by 3/1/09. On-going monitoring will continue through quarterly chart reviews to be conducted by the Touchmark RN nurse consultant. And, daily review of visit notes and physician orders by the DPS Patient Care Coordinator.*	

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G 236	Continued From page 17 at high risk of falling A form titled "Assessment of Need for Interdisciplinary Referral,"dated 12/22/08, identified the patient as "frail with safety concerns, living alone - elderly." During an interview on 1/5/09 at 4:34 PM, the RN Case Manager (Staff D) stated she offered the patient aide services and social work services but the patient declined the services. There was no documentation found in the clinical record that aide or social work services were offered to the patient and refused. The RN Case Manager confirmed that the information may not have been documented in the record. The agency failed to ensure SN documented pertinent information in the clinical record relating to interventions taken on behalf of the client but refused. 2. Patient #2, whose SOC date was 07/31/08, was admitted for care primarily related to a urinary tract infection. A form, dated 07/30/08 and titled "Therapy Referral Form," documented that the patient needed help with a new gluten free diet. There was an undated, unsigned note written diagonally across this form in pink highlighter pen stating the patient had refused. No reason was documented for the patient's refusal or how this information had been communicated from the patient. During an interview on 1/5/09 at 1:53 PM, the Administrator reviewed the record and confirmed the note was undated and unsigned. 3. Patient #6 was a 73 year old female whose SOC was 9/4/08. Her diagnosis was a progressive neurological disorder. An order for social services, dated 11/6/08, stated the MSW was to see the patient 2-3 times a month for 2	G 236		

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G 236	Continued From page 18 months. MSW notes documented 6 social service visits to the patient between 11/6/08 and 12/16/08. The patient was recertified on 1/3/09. A new POC was not present in the record and it was not clear if the MSW planned to continue to see the patient or not as of 1/6/09. Staff D, the RN Case Manager for Patient #6, was interviewed on 1/6/09 at 10:30 AM. She confirmed minutes of case conferences and nursing notes did not document coordination with the MSW. She said she had talked with the MSW the week before Christmas and said the MSW was planning to continue to provide services. Staff D stated she had not document this and said due to the holidays, some of her charting had not been completed yet. 4. Patient #14 was a 39 year old female whose SOC was 12/17/08. Her diagnosis was hyperemesis gravidarum (vomiting during pregnancy). A POC, CMS 485, was not present in her medical record. A "Skilled Nursing Treatment Plan", dated 12/17/08, was present in the record but it had not been signed by a physician. Staff C, Patient #14's case manager, was interviewed on January 7, 2009 at 11:28 AM when she reviewed the patient's record. She stated nursing visits had been made on 12/17, 12/18, and 12/19/08. A progress note for the 12/18/08 visit was not present in the record. Staff C confirmed a POC signed by the physician was not present. She also confirmed the progress note for 12/18/08 was not present.	G 236		
G 250	484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether	G 250	**G250 – Clinical Record Review** Touchmark RN nurse consultant to visit 4 times each year and conduct the required quarterly chart reviews. Interdisciplinary chart reviews will also be coordinated by the Director	

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G 250	Continued From page 19 established policies are followed in furnishing services directly or under arrangement. This STANDARD is not met as evidenced by: Based on staff interview and review of agency policies and quality improvement documents, it was determined the agency failed to ensure a sample of clinical records was reviewed at least quarterly for 2 of 4 quarters (no review 4th quarter 2007 and 3rd quarter 2008). This prevented the agency from receiving feedback regarding the completeness of the documentation and whether staff were following agency policies. The findings include: The policy "QUALITY ASSURANCE AND IMPROVEMENT", dated September 2006, stated a Quality Assurance and Improvement Committee would meet at least quarterly and "Complete a quarterly chart audit covering all aspects of care...no less than 10 charts per quarter will be audited." This policy was not followed. Quality improvement reports since October 2007 documented 6 medical records were reviewed from the first quarter of 2008 (4 closed records and 2 open) and 6 records were reviewed from the 2nd quarter of 2008 (6 open records). No records were documented as reviewed for the 4th quarter 2007 and 3rd quarter of 2008. Also, the Administrator, interviewed on 1/7/08 at 1:50 PM, stated no data was compiled from the reviews. She said individual nurses were counseled if problems were found but data was not collected to determine if agency policies were being followed.	G 250	of Professional Services to the individual therapy services. The nurse consultant will make first her quarterly visit the week of 2/8/09. She will then visit in April, July, September, and January of each year. Administrator and Director of Professional Services will review and revise policy14.1 Quality Assurance and Improvement. This review will be completed by 3/1/09.	

Bureau of Facility Standards

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the survey were: Teresa Hamblin RN, MS, HFS, Team Leader Gary Guiles, RN, HFS Acronyms in this report include: HHA = Home Health Agency POC = Plan of Care	N 000	RECEIVED FEB 04 2009 FACILITY STANDARDS	
N 039	03.07020. ADMIN.GOV. BODY N039 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: a) The extent to which payment may be expected from third party payors.; and This Rule is not met as evidenced by; Refer to Federal Tag G114 as it relates to the failure of the HHA to ensure patients were informed in writing in advance of care the extent to which payment could have been required from the patient.	N 039	**N039 – See G114 response** ***G114 – Patient Liability for Payment*** *Administrator and Director of Professional Services (DPS) to review and revise policies 2.7 Payer Source Verification and 15.6 Client Consent for services. Visit staff to be in-serviced by 3/1/09 on these policies and accurate completion of the client consent. On 1/9/09, the Patient Care Coordinator was verbally instructed on the correct method these forms were to be completed. The Patient Care Coordinator will now monitor on-going with each new start of care. Any discrepancies to be noted and reported to the Administrator and DPS for immediate correction and individual staff re-education. Accuracy of completion to also be monitored through periodic and quarterly chart reviews.*	
N 051	03.07021. ADMINISTRATOR N051 03. Responsibilities. The administrator, or his designee, shall	N 051	**N051 – Administrator** Administrator and Director of Professional Services to monitor	

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N 051	Continued From page 1 assume responsibility for: e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations. This Rule is not met as evidenced by: Based on staff interview, review of personnel files and review of HHA policies, it was determined the HHA failed to ensure current cardiopulmonary resuscitation (CPR) certification in 2 of 9 employees (#1 and #2) requiring CPR certification whose personnel records were reviewed. This had the potential to compromise patient safety. Findings include: Personnel Record #1 had a CPR card that expired 12/08. Personnel Record #2 had a CPR card that expired 3/08. During an interview on 1/7/09 at 11:07 AM, the Administrator confirmed the outdated CPR cards. A policy titled "Personnel Files," dated March 2007, stated that current CPR certification was required for all employees. The HHA failed to ensure staff maintained a current CPR card.	N 051	through weekly review of "Employee Requirements Due" report during a weekly office meeting. This requirements due report is generated by the Billing Coordinator who has the responsibility of monitoring employee files/human resource duties. The Billing Coordinator will notify individual employees and contractors about items due to expire and request proof that the required item has been renewed. The Billing Coordinator will notify the Administrator when items are not renewed so that immediate action may be taken. This process has been implemented as of 2/2/09. Ongoing review and monitoring will occur weekly by the Billing Coordinator, Administrator and Director of Professional Services.	

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N 062	Continued From page 2	N 062	**N062 – Admministrator** **See G144 response** ***G144 – Coordination of Patient Services*** *Administrator and DPS to review and revise policies 13.9 Progress Notes, 13.2 Client Clinical Records, 14.3 Client Care Conferences and 6.5 Documentation Guidelines. Staff will be in-serviced regarding policies and the accurate/proper methods for documenting in the medical record. Visit staff to be in-serviced on these policies and proper documentation by 3/1/09. On-going monitoring will continue through quarterly chart reviews to be conducted by the Touchmark RN nurse consultant. And, daily review of visit notes and physician orders by the DPS Patient Care Coordinator.*	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to Federal Tag G144 as it relates to the failure of the HHA to ensure the clinical record established effective interchange, reporting, and coordination of patient care.	N 062		
N 119	03.07024.04.SK.NSG.SERV. N119 04. Supervisory Visits. A registered nurse or therapist makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days. This Rule is not met as evidenced by: Refer to Federal Tag G229 as it relates to the failure of the HHA to provide aide supervisory visits no less frequently than every 2 weeks.	N 119	**N119 - Skilled Nursing Service** **See G229 response** ***G229 – Supervision*** *The agency currently utilizes the "Requirements Due Report" functionality within the software program. The report is printed and provided to each visit nurse to remind them of when supervisory visits are due. Effective 1/9/09, the Patient Care Coordinator has been instructed to also provide a copy of this report to the Director of Professional Services. The DPS will then monitor and follow up with any staff that is delinquent on making the required 14 day supervisory visits. These reports are printed weekly. Ongoing review for compliance will also occur through the quarterly chart review process and random review.*	

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N 152	Continued From page 3	N 152	**N152 – Plan of Care** **See G158 response** ***G158 – Acceptance of Patients, POC, Med Super*** *Administrator and DPS to review and revise policies 6.5 Hold Resume Requirements and 6.3 Client Plan of Care. Visit staff to be in-serviced on these policies, resumption of care procedure, cancelled missed visit report and scheduling procedure that coincides with the computer program utilized by the agency. In-service will be completed by 3/1/09. See also response to G144 as it relates to this citation. On-going monitoring will be conducted by the Patient Care Coordinator. DPS and/or Administrator to be notified when visit notes are missing and no schedule change request submitted by the visit staff. Monitoring will also be conducted through quarterly chart reviews by interdisciplinary team and RN nurse consultant. Use of the software program will be reviewed with the clerical staff for proper entry and tracking of all physician orders and the 485 (plan of care). This will allow for monitoring and tracking of the timing of 485 completion and submission to the MD. This review will be completed by 2/15/09.*	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to Federal Tag G158 as it relates to the failure of the HHA to follow a written plan of care established and periodically reviewed by a doctor.	N 152		
N 162	03.07030.PLAN OF CARE N162 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: j. Any safety measures to protect against injury; This Rule is not met as evidenced by: Refer to Federal Tag G159 as it relates to the failure of the HHA to develop a plan of care (POC) in consultation with agency staff that covered all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.	N 162	**N162 – Plan of Care** **See G159 response** ***G159 – Plan of Care*** *Administrator and DPS to review the policy and procedure for the Fall Risk Assessment Form. The nursing plan of care worksheet will also be reviewed and revised to include safety measures for care planning if identified during the comprehensive*	

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N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to Federal Tag G164 as it relates to the failure of the HHA to ensure profesisonal staff promptly alerted the physician to any changes that suggested a need to alter the plan of care.	N 172	*assessment. The office procedure for submitting and faxing physician orders to be reviewed and revised to allow for a review of the plan of care prior to faxing to the physician by the DPS. Review and revision of the items noted in G159 will be completed by 3/1/09. Ongoing review and monitoring will occur through the quarterly chart review process identified earlier.* **N172 – Plan of Care** **See G164 response** *G164 – Periodic Review of Plan of Care* *Administrator and Director of Professional Services to review and revise policy 8.1 Medical Policies and Physician's Orders. Visit staff to be in-serviced on this policy by 3/1/09. Ongoing review will occur through daily review of the visit notes by the Director of Professional Services.*	
N 180	03.07031.CLINICAL REC. N180 02. Contents. Clinical records must include: f. Signed and dated clinical and progress notes; This Rule is not met as evidenced by: Refer to Federal Tag G236 as it relates to the HHA's failure to ensure signed and dated clinical progress notes.	N 180	**N180 – Clinical Records** **See G236 response** ***G236 – Clinical Records*** *Please see response to G144 as it relates to this citation.* ***G144 – Coordination of Patient Services*** *Administrator and DPS to review and revise policies 13.9 Progress Notes, 13.2 Client Clinical Records, 14.3 Client Care Conferences and 6.5 Documentation Guidelines. Staff will be in-serviced regarding policies and the accurate/proper methods for documenting in the medical record. Visit staff to be in-serviced on these policies and proper documentation by 3/1/09. On-going monitoring will continue through quarterly chart reviews to be conducted by the Touchmark RN nurse consultant. And, daily review of visit notes and physician orders by the DPS Patient Care Coordinator.*	
N 197	03.07050. CINICAL REC. REVIEW N197 050. CLINICAL RECORD REVIEW. The agency shall have a subcommittee to perform an audit of clinical records on at least a quarterly basis to determine the adequacy of services provided in meeting patient's needs. The committee members will represent the scope of the program consisting of health professionals. The review shall consist of at least ten per cent (10%) sampling of both active and closed clinical records representing all	N 197		

Bureau of Facility Standards

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N 197	Continued From page 5 services being offered. A written summary of findings and recommendations of the committee shall be utilized in the overall review and self-evaluation of the agency. This Rule is not met as evidenced by: Refer to Federal Tag G250 as it relates to the HHA's failure to do quarterly record review.	N 197	**N197 – Clinical Rec. Review** **See G250 response** ***G250 – Clinical Record Review*** *Touchmark RN nurse consultant to visit 4 times each year and conduct the required quarterly chart reviews. Interdisciplinary chart reviews will also be coordinated by the Director of Professional Services to the individual therapy services. The nurse consultant will make first her quarterly visit the week of 2/8/09. She will then visit in April, July, September, and January of each year. Administrator and Director of Professional Services will review and revise policy14.1 Quality Assurance and Improvement. This review will be completed by 3/1/09.*	
N 199	Criminal History and Background Check 009.CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS. 01. Compliance with Department ' s Criminal History and Background Check. A home health agency must comply with IDAPA 16.05.06, " Criminal History and Background Checks. " (3-26-08) 02. Direct Patient Access Individuals. These rules apply to employees and contractors hired or contracted with after October 1, 2007, who have direct patient access. (3-26-08) 03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must complete an application before having access to patients. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any patient without a clearance by the Department. Once the notarized application is completed the individual can only work under supervision until the individual has been fingerprinted. The individual must have his fingerprints submitted to the Department within twenty-one (21) days of completion of the notarized application. (3-26-08)	N 199	**N199 – Criminal History and Background Check** Administrator to review the IDAPA regulations on Criminal History and Background checks and educate employees responsible for hiring of the need to complete for every employee including contractors. The Billing Coordinator to review all employee and contractor files for missing background check information. This review of the files has been completed as of 1/31/09. Arrangements have been made for those contractors requiring	

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N 199	Continued From page 6 This Rule is not met as evidenced by: Based on review of employee files and interview with HHA staff, it was determined the HHA failed to ensure or confirm criminal background checks were obtained for 5 of 9 employees (#5, #6, #7, #8, and #9) whose personnel records were reviewed. This had the potential to expose patients to employees with a criminal background. Findings include: Personnel #5, a Social Worker with a 1/21/08 date of hire, did not have a criminal background check on file. Personnel #6, a Speech Therapist with a 7/01/08 date of hire, did not have a criminal background check on file. Personnel #7, a Physical Therapist with a 9/23/08 date of hire, did not have a criminal background check on file. Personnel #8, an Occupational Therapist with a 11/01/08, did not have a criminal background check on file. Personnel #9, a Dietician with an undetermined date of hire, did not have a criminal background check on file. During an interview on 1/7/09 at 11:07 AM, the Administrator confirmed the missing criminal background checks. She explained that Personnel #5 had applied for a criminal background check but the HHA had not yet received the results. The Administrator further explained it had not been the HHA's practice to get criminal background checks on contract employee staff. She considered the Dietician	N 199	background checks to be completed. Expected completion date 3/1/09. On-going reviews will be conducted with each new hire and periodic reviews of the employee and contractor files.	

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N 199	Continued From page 7 more of a consultant than contract staff since the HHA could not bill Medicare for her services. She was uncertain of the hire date. A policy titled "Personnel Files," dated March 2007, stated that a criminal check (as required by law) is required for all employees.	N 199		